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A. TYPE OF HANDBOOK

Part H, Division II, Mental Health and Alcohol and Other Drug Abuse (AODA) Services: 51.42 Board Owned-and-Operated Clinics, is the service-specific portion of the Wisconsin Medical Assistance Provider Handbook. Part H, Division II, includes information for providers regarding provider eligibility criteria, recipient eligibility criteria, covered services, prior authorization procedures, and billing instructions. Part H, Division II is intended to be used in conjunction with Part A of the Wisconsin Medical Assistance Provider Handbook which includes general policy guidelines, regulations, and billing information applicable to all types of providers certified in the Wisconsin Medical Assistance Program (WMAP).

The information in Part H, Division II of the handbook applies only to providers who are certified as 51.42 Board owned and operated outpatient psychotherapy or AODA clinics.

Hospitals providing mental health and AODA services through a hospital outpatient mental health or AODA clinic are subject to the policies and prior authorization procedures outlined in this handbook. However, the billing information does not apply to hospitals since they use a different claim form. As specified in HSS 107.08(3)(b)2. Wis. Admin. Code, outpatient services performed outside the hospital facility may not be reimbursed as hospital outpatient services. Therefore, clinics which are owned and operated by hospitals, but which are not located at the site of the hospital, must be separately certified as outpatient psychotherapy clinics. These clinics are subject to all policies in this handbook. These clinics must bill services on the HCFA 1500 claim form.

Since HSS 105, Wis. Admin. Code, contains distinct certification requirements for separate programs, agencies providing other types of mental health programs (e.g. day treatment, Community Support Programs) are required to obtain separate WMAP certification for each of these programs. Providers may contact EDS for certification materials. Refer to Appendix 2 of Part A of the WMAP Provider Handbook for information on how to contact EDS. Separate DCS certification is required for each type of mental health program.

Providers who are also certified to provide other WMAP covered mental health/AODA services should refer to the appropriate service-specific handbooks for information on those services. Part H, Division I, is for use by non-51.42 Board-Operated Clinics providing mental health and AODA services. Part H, Division III, is for Mental Health Day Treatment providers. Part H, Division IV, is for AODA Day Treatment providers. Part H, Division V is for Community Support Program (CSP) providers.

Please note that the qualifications, definitions and procedures for psychotherapy differ from AODA treatment and are separately described throughout this handbook.

B. PROVIDER INFORMATION

Eligibility for Certification of Psychotherapy Providers

In order to be certified as a WMAP psychotherapy provider, one of the following requirements must be met:

A 51.42 Board Owned-and-Operated psychotherapy clinic must be certified by the Division of Community Services (DCS) of the Department of Health and Social Services (DHSS) as meeting the outpatient psychotherapy clinic standards under HSS 61.91 to 61.98, Wis. Admin. Code. Staff providing services which are billed to the WMAP must meet the following criteria but do not need to be individually certified by the WMAP:

A psychiatrist must be a licensed physician under ch. 448, Wis. Stats., who has completed a residency in psychiatry.

B. PROVIDER INFORMATION (continued)

A psychologist must be licensed under ch. 455, Wis. Stats., and be listed or eligible to be listed in the National Register of Health Service Providers in Psychology. A psychologist licensed under ch. 455, Wis. Stats., with the academic credential of a doctoral degree who is not eligible for listing in the National Register, is considered a master's level provider.

A master's degree psychotherapist must be employed by the clinic and must meet the requirements listed in HSS 61.96 (1)(b) or (2), and HSS 61.96(3), Wis. Admin. Code.

Important Note: All psychotherapists at 51.42 Board-operated clinics who provide services to recipients who are dually eligible for Medical Assistance and Medicare must be individually certified by the WMAP in order for reimbursement to occur.

Eligibility for Certification of AODA Treatment Providers
In order to be certified as a WMAP AODA treatment provider, a 51.42 Board Owned-and-Operated AODA Clinic must be certified by DCS as meeting the outpatient treatment program standards under HSS 61.59, Wis. Admin. Code.

Staff providing services which are billed to the WMAP must meet the following criteria but need not be individually certified:

A physician must be licensed under ch. 448, Wis. Stats.

A psychologist must be licensed under ch. 455, Wis. Stats., and be listed or eligible to be listed in the National Register of Health Service Providers in Psychology. A psychologist licensed under ch. 455, Wis. Stats., with the academic credential of a doctoral degree who is not eligible for listing in the National Register is considered a master's level provider.

A master's degree psychotherapist must be employed by the clinic and meet the requirements listed in HSS 61.96(1)(b) or (2), and HSS 61.96 (3), Wis. Admin. Code.

An alcohol and/or drug counselor must be employed by the clinic and must be certified by the Wisconsin Alcoholism Counselor Certification Board. An alcohol and/or drug counselor who is not certified by the Wisconsin Alcoholism Counselor Certification Board but has a development plan on file does not meet this requirement.

Certification as Psychotherapy and AODA Treatment Providers
Providers are encouraged to apply for certification materials through EDS prior to the time of their DCS certification site visit in order to ensure the earliest possible certification effective date.

A 51.42 Board Owned-and-Operated clinic meeting the eligibility requirements for psychotherapy or AODA treatment that wishes to be certified as a WMAP psychotherapy or AODA clinic must contact:

EDS
Attn: Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

The clinic is required to submit a copy of the approval letter from the DCS of the DHSS to verify that it has been certified to provide psychotherapy and/or AODA services in Wisconsin.

Scope of Service
The policies in Part H, Division II, govern services provided within the scope of practice as defined HSS 107.13 (2) and (3), Wis. Admin. Code. Covered services and related limitations are listed in Section II of this handbook.

B. PROVIDER INFORMATION (continued)

Reimbursement

Mental health and AODA providers in non-Board operated clinics are reimbursed for most services at the lesser of the provider's usual and customary charge or the maximum allowable fee established by the DHSS. However, reimbursement rates for some services provided by 51.42 Board Owned-and-Operated clinics are provider-specific. Information about current rates established for 51.42 Board Owned-and-Operated clinics may be obtained by writing to:

Mental Health/AODA Policy Analyst
Bureau of Health Care Financing
1 West Wilson Street
Post Office Box 309
Madison, WI 53701-0309

Providers are required to bill the WMAP their usual and customary charge for services provided, that charge being the amount charged by the provider for the same service when provided to private-pay patients. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Further information on billing is found in Section IV of this handbook.

Master's degree psychotherapists and AODA counselors are non-billing performing providers and may not be directly reimbursed for services they provide. Reimbursement for services performed by these providers may be made only to the certified clinic which employs them. Refer to Section IV-F of this handbook for billing instructions.

Provider Responsibilities

Specific responsibilities as a provider under the WMAP are stated in Section IV of Part A of the WMAP Provider Handbook. This section should be referenced for detailed information regarding fair treatment of the recipient, maintenance of records, recipient requests for noncovered services, services rendered to a recipient during periods of retroactive eligibility, grounds for provider sanctions, and additional state and federal requirements.

C. RECIPIENT INFORMATION

Eligibility For Medical Assistance

Recipients meeting eligibility criteria for the WMAP are issued Medical Assistance identification cards. The identification cards include the recipient's name, date of birth, 10-digit Medical Assistance identification number, medical status code, and when applicable, an indicator of health insurance coverage, managed care program coverage, and Medicare coverage.

Medical Assistance identification cards are sent to recipients monthly. All Medical Assistance identification cards are valid only through the end of the month for which they are issued. It is important that the provider or the designated agent check a recipient's Medical Assistance identification card prior to providing service to determine if the recipient is currently eligible and if there are any limitations to the recipient's coverage.

Section V of Part A of the WMAP Provider Handbook provides detailed information regarding eligibility for the WMAP, Medical Assistance identification cards, temporary cards, restricted cards, and how to verify eligibility. Review Section V of Part A carefully before services are rendered. A sample Medical Assistance identification card may be found in Appendix 7 of Part A of the WMAP Provider Handbook.

C. **RECIPIENT INFORMATION** (continued)

Medical Status

Medical Assistance recipients are classified into one of several eligibility categories, including qualified Medicare beneficiary-only (QMB-only). These categories allow for a differentiation of benefit coverage.

Additional information regarding medical categories may be found in Section V of Part A of the WMAP Provider Handbook.

Copayment

Except as noted below, all recipients are responsible for paying part of the costs involved in obtaining mental health and AODA services. The procedure codes and their applicable copayment amounts may be found in Appendix 15 of this handbook.

Providers are reminded of the following copayment exemptions:

- Emergency services
- Services provided to nursing home residents
- Services provided to recipients under 18 years of age
- Services provided to a pregnant woman if the services are related to the pregnancy
- Services covered by WMAP-contracted managed care programs to enrollees of the WMAP-contracted managed care program

Copayment must be collected from the recipient by the provider of service. Applicable copayment amounts are automatically deducted by EDS from payments allowed by the WMAP. Do not reduce the billed amount of the claim by the amount of recipient copayment. Refer to Section IV of Part A of the WMAP Provider Handbook for further information on copayment.

Managed Care Program Coverage

WMAP recipients enrolled in WMAP-contracted managed care programs receive a yellow Medical Assistance identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's managed care program. These codes are defined in Appendices 20, 21, and 22 of Part A of the WMAP Provider Handbook.

Providers must always check the recipient's current Medical Assistance identification card for managed care program coverage before providing services. Claims submitted to EDS for services covered by WMAP-contracted managed care programs are denied.

WMAP-contracted managed care programs are required to cover all WMAP-covered mental health and AODA services. Further, managed care programs must guarantee that all Medical Assistance recipients enrolled in WMAP-contracted managed care programs have access to all medically necessary outpatient mental health and AODA services. No limit may be placed on the number of hours of outpatient treatment which the managed care program provides or reimburses when it is determined that treatment for mental or nervous disorders, alcohol or drug abuse is medically necessary. Managed care programs may not establish any monetary limit or limit on the number of days of inpatient hospital treatment when it is determined that this treatment is medically necessary. Managed care programs may establish their own authorization procedures.

C. **RECIPIENT INFORMATION** (continued)

For recipients enrolled in a WMAP-contracted managed care program, all conditions of reimbursement and prior authorization for mental health and AODA services are established by the contract between the managed care programs and certified providers.

Additional information regarding managed care program noncovered services, emergency services, disenrollment and hospitalizations is included in Section IX of Part A of the WMAP Provider Handbook.

Recipient Eligibility for Mental Health and Alcohol and other Drug Abuse Services
As specified in HSS 107.03(15), Wis. Admin. Code, the following recipients are not eligible for services through the WMAP:

1. an individual who is currently in jail or a correctional facility; and

2. an individual 21 to 64 years of age who is a resident of an institution for mental disease (IMD), unless the recipient is 21 years of age, was a resident of the IMD immediately prior to turning 21 and has been continuously a resident since then, unless the individual is on convalescent leave. (If these conditions are met, treatment may be provided up to the recipient's 22nd birthday.) "Convalescent leave" means a resident's temporary release from an IMD to

   residency in a community setting, not more frequently than once a year and beginning on the fourth day after release. The trial period of residence in the community must last at least four days but no longer than 30 days, or until the recipient is permanently discharged from the IMD, whichever occurs first.

Any WMAP payments made on these claims must be returned to the WMAP. Medicare claims for coinsurance/deductible are not reimbursable by the WMAP for recipients in an IMD.

A. INTRODUCTION

Covered services are those described in the HSS 107.13 (2) and 107.13(3), Wis. Admin. Code, when delivered by providers certified in accordance with HSS 105.22 (for psychotherapy providers) and HSS 105.23 (for Alcohol and Other Drug Abuse [AODA] providers), Wis. Admin. Code. Please refer to Appendix 3 of this handbook for a complete list of allowable procedure codes for mental health and AODA services, along with information on which psychotherapy and AODA providers may bill each procedure code, limitations which apply to the procedure codes, and allowable diagnoses.

B. COVERED PSYCHOTHERAPY SERVICES

Requirements for Psychotherapy Services

Recordkeeping and General Requirements

The following record keeping and general requirements are outlined in HSS 61.97. (11) - (15) Wis. Admin. Code.

An initial assessment must be performed by staff to establish a diagnosis on which a preliminary treatment plan is based, which shall include but is not limited to:

- the recipient's presenting problems with the onset and course of symptoms, past treatment response, and current manifestation of the presenting problems;
- preliminary diagnosis; and
- personal and medical history.

A treatment plan must be developed with the recipient upon completion of the diagnosis and evaluation.

Progress notes must be written in the recipient's clinical record. The notes shall contain status and activity information about the recipient that relates to the treatment plan. Progress notes are to be completed and signed by the therapist performing the therapy session.

A discharge summary containing a synopsis of treatment given, progress and reasons for discharge shall be written in the recipient's clinical record when services are terminated.

All recipient clinical information received by the provider shall be kept in the recipient's clinical record. The following requirements must be met:

- recipient records must be stored in a safe and secure manner;
- policy must be developed to determine the disposition of recipient clinical records in the event of closing;
- a written policy governing the disposal of recipient clinical records must be developed;
- recipient clinical records must be kept at least five years;
- upon termination of a staff member, the recipient clinical records for which he or she is responsible must remain in the custody of the clinic where the recipient was receiving services unless the recipient requests, in writing, that the records be transferred; and
- upon written request of the recipient, the provider must transfer the clinical information required for further treatment as determined by the supervising physician or psychologist.

B. COVERED PSYCHOTHERAPY SERVICES (continued)

Based on reviews of recipient records, the WMAP believes that recordkeeping can be enhanced by the following good practices:

- including information in the assessment on previous treatment history and outcome, making sure the assessment materials support the diagnosis made, and updating assessment materials as new information becomes available;
- including both short-term and long-term measurable goals in the treatment plan; and
- including information in the discharge summary on the provider's response to non-compliance, including efforts to engage the recipient in treatment, when this was a factor in discontinuing treatment. Also, identify how a return to treatment might be most easily handled.

Refer to Section IV of Part A of the WMAP Provider Handbook for further information regarding recordkeeping.

Outpatient psychotherapy services are a covered benefit when provided under the following conditions:

- treatment is provided in accordance with the definition of psychotherapy;

  Psychotherapy is defined in HSS 101.03(145) Wis. Admin. Code, as "the treatment of an individual who is mentally ill or has medically significant emotional or social dysfunctions by a psychotherapy provider. The treatment is a planned and structured program based on information from a differential diagnostic examination and directed at the accomplishment of specified goals. The treatment goals may include removing, modifying, or retarding existing symptoms, mediating disturbed patterns of behavior, and promoting positive personal growth and development by enhancing the ability to adapt and cope with internal and external stresses."

- a differential diagnostic examination is performed by a certified psychotherapy provider. A physician's prescription is not required to perform the examination. Any WMAP certified psychotherapy provider may perform the differential diagnostic examination;

  A differential diagnostic examination is defined in HSS 101.03(42), Wis. Admin. Code, as "an examination and assessment of a recipient's emotional and social functioning which includes one or more of the following: neurological studies, psychological tests and psycho-social assessments."

- before the actual provision of psychotherapy services, a physician (this need not be a psychiatrist) prescribes the therapy in writing. Prescriptions must include the length of time that services are expected to be required. The length of time may be up to one year. New prescriptions are required after one year; and

- the provider who performs psychotherapy meets the requirements of a psychotherapy provider as described in Section I-B of this handbook and engages in face-to-face contact with the recipient for at least 5/6 of the time for which reimbursement is claimed.

B. **COVERED PSYCHOTHERAPY SERVICES** (continued)

Psychiatric Evaluation and Diagnostic Testing

Up to six hours of face-to-face psychiatric evaluation or diagnostic testing during a two year period may be provided without prior authorization. Time spent scoring and interpreting diagnostic tests and writing up the results of the evaluation are allowable parts of diagnostic testing. These six hours do not count towards the 15 hours or $500 prior authorization threshold for psychotherapy/AODA services. Evaluation and testing services provided to a recipient by any certified psychotherapy provider count toward the two year evaluation threshold.

Services by a psychiatrist or psychologist provided at the inpatient hospital setting and separately billed as a professional service are not subject to prior authorization.

When evaluation services by any combination of psychotherapy providers exceed six hours in a two-year period, the provider may seek prior authorization for the evaluation. Psychiatric evaluation and diagnostic testing in excess of six hours in a two-year period must be prior authorized to be paid as a psychiatric evaluation. Refer to Section III of this handbook for information on requesting prior authorization for psychiatric evaluation and testing.

Psychiatric evaluations in excess of six hours in a two year period that do not have prior authorization are denied and may be rebilled as limitation exceeded psychotherapy, or if the limit was exceeded because the services were provided by more than one provider, backdating of the prior authorization request may be allowed. Refer to Section III-G of this handbook for information on backdating prior authorization requests. Psychiatric evaluations and diagnostic testing services are not subject to a diagnosis restriction and do not require a referring/prescribing provider.

Allowable psychiatric evaluations and diagnostic testing services include:

- the initial differential diagnostic examination;
- assessments necessitated by changes in the individual's behavior, environment, physical or psychological condition which are required to determine whether changes need to be made in the recipient's treatment plan;
- assessments or evaluations which are performed with the recipient as a part of supervisory oversight;
- time spent in face-to-face contact with a recipient as part of a consultation requested by the primary psychotherapy provider;
- psychiatric evaluations which are required pursuant to legal proceedings to determine an individual's mental competency, if the recipient is not incarcerated at the time of the evaluation;
- evaluations or assessments which are performed on children or adolescents pursuant to legal proceedings to determine the necessity for out-of-home placement; and
- court appearances to defend against commitment.

Neuropsychological testing is considered a neurological service and is not subject to the policy described in this handbook. Procedure codes for neuropsychological testing may be billed by WMAP-certified physicians or psychologists.

B. COVERED PSYCHOTHERAPY SERVICES (continued)

Evaluation techniques and instruments are to include those which are accepted as the standard of practice (e.g., psychological testing instruments should be listed in the latest edition of the Mental Measurements Handbook). The provider must have training in the use of the particular instrument being employed.

Limitation-Exceeded Psychotherapy

Limitation-exceeded psychotherapy is used to bill allowable psychiatric evaluation and diagnostic testing services when any combination of providers has exceeded the six hour per two-year limit when evaluation services have not been prior authorized. The limitation-exceeded psychotherapy procedure codes, like psychiatric evaluations, are not subject to a diagnosis restriction and do not require a referring/prescribing provider. However, they do count toward the 15 hour/$500 yearly prior authorization threshold for psychotherapy/AODA services and are denied if this threshold has been exceeded and the provider does not have prior authorization. Refer to Section III of this handbook for information on requesting prior authorization for evaluations and diagnostic testing.

Services by a psychiatrist or psychologist provided at the inpatient hospital setting and separately billed as a professional service are not subject to prior authorization.

Individual Psychotherapy

Individual psychotherapy is covered when it meets the requirements for psychotherapy services above. Specialized forms of individual treatment, such as narcosynthesis, hypnotherapy, medical psychoanalysis, and biofeedback, should be performed by providers who have specific training and experience in the use of these techniques. Providers should refer to Appendix 3 of this handbook for information on who may bill for these procedures and limitations that may apply. Only one provider may bill for a particular treatment session.

Family Psychotherapy

Family psychotherapy is covered for the recipient, the recipient's immediate family member(s), and the recipient's significant others. Immediate family members include parents, foster parents, spouse, children, or foster children. The recipient who is the identified mental health client must be present in order for the session to be billed as family psychotherapy. Such a session may involve more than one recipient, but only one provider may bill for one recipient for a particular treatment session. No more than two providers may bill for the same family psychotherapy session.

Family psychotherapy without the recipient present is also covered for members of the recipient's immediate family as defined in the previous paragraph and must be billed under the procedure code for "Family Medical Psychotherapy (without recipient present)."

Group Psychotherapy

Group psychotherapy is defined as a session in which more than one but not more than ten individuals (they do not all need to be Medical Assistance recipients) receive psychotherapy services together from one or two providers. No more than two providers may be reimbursed for the same session, and they may not claim reimbursement for the same recipients in the group.

Group psychotherapy is considered a hospital service when provided to an inpatient and may not be separately billed as a professional service by any professional discipline. The recipient who is the identified mental health client must be present in the group in order for the session to be billed.

B. COVERED PSYCHOTHERAPY SERVICES (continued)

Emergency Psychotherapy

Emergency psychotherapy may be performed by a provider for a recipient even if the required prescription for treatment or prior authorization has not been obtained prior to the provision of care when the provider has reason to believe that the recipient is an immediate threat to him/herself or others. A prescription for the emergency treatment must be obtained within 48 hours of the time the emergency treatment was provided, excluding weekends and holidays. Emergency psychotherapy requires prior authorization before payment is made if the recipient has exceeded the 15 hour/ $500 limit for services in a calendar year. Refer to Section III of this handbook for information on requesting prior authorization.

Psychotherapy Medication Management (Medication Check)

Psychotherapy medication management is a covered service when provided by a physician or a registered nurse. Psychotherapy medication management includes the prescription, directions on the use of, and review of medication, with no more than minimal psychotherapy. When physicians or registered nurses provide chemotherapy management, they may also administer the medication.

Psychotherapy medication management is considered a hospital service when provided to hospital inpatients and may not be separately billed as a professional service.

C. COVERED AODA TREATMENT SERVICES

Requirements for AODA Treatment Services

Recordkeeping and General Requirements

The following recordkeeping requirements are taken from HSS 61 52(5)-(12), Wis. Admin. Code.

There shall be a case record for each recipient and contact register for all service inquiries.

The case recordkeeping format shall provide for consistency, facilitate information retrieval, and shall include the following:

1. Consent for treatment forms signed by the recipient.
2. Acknowledgement of program policies and procedures which is signed and dated by the recipient.
3. Reports from referring sources.
4. Results of all examinations, tests, and other assessment information.
   An assessment shall be done by members of the clinical staff and shall be clearly explained to the recipient and to the recipient's family, when appropriate, and must include the following:
   - identification of the alcohol or drug abused, frequency and duration of use, method of administration and relationship to the recipient's dysfunction; and
   - available information on the recipient's family, legal, social, vocational, and educational history.
5. Treatment plans
   Based on the assessment made of the recipient's needs, a written treatment plan shall be developed and recorded in the recipient's case record.

   A preliminary treatment plan shall be developed as soon as possible, but not later than five working days after the recipient's admission.

C. COVERED AODA TREATMENT SERVICES (continued)

Treatment may begin before completion of the plan.

The plan shall be developed with the recipient, and the recipient's participation in the development of treatment goals shall be documented.

The plan shall specify the services needed to meet the recipient's needs and attain the agreed upon goals.

The goals shall be developed with both short and long range expectations and written in measurable terms.

The plan shall describe criteria to be met for termination of treatment.

6. Medication records which shall allow for ongoing monitoring of all medications administered and the detection of adverse drug reactions. All medication orders in the recipient case record shall specify the name of the medication, dose, route of administration, frequency of administration, person administrating, and name of the physician who prescribed the medication.

7. Multidisciplinary case conference and consultation notes
Recipient progress and current status in meeting the goals set in the plan shall be reviewed by the recipient's treatment staff at regularly scheduled case conferences.

The date and results of the review and any changes in the treatment plan shall be written into the recipient's record.

The participants in the case conference shall be recorded in the case record.

8. Correspondence including all letters and dated notations of telephone conversations relevant to the recipient's treatment.

9. Consent for disclosure of information release forms.

10. Progress notes
Progress notes shall be regularly entered into the recipient's case record.

Progress notes shall include the following:

- chronological documentation of treatment given to the recipient which shall be directly related to the treatment plan;
- documentation of the recipient's response to and the outcome of treatment; and
- progress notes shall be dated and signed by the person making the entry.

11. Record of services provided which shall include summaries sufficiently detailed so that the person not familiar with the program may identify the types of services the recipient has received.

12. Discharge documentation
A discharge summary shall be entered in the recipient's case record within one week after termination of treatment.

The discharge summary shall include:

- a description of the reasons for discharge;

C. COVERED AODA TREATMENT SERVICES (continued)

- the recipient's treatment status and condition at discharge;
- a final evaluation of the recipient's progress towards the goals set forth in the treatment plan; and
- a plan developed, in conjunction with the recipient, regarding care after discharge and follow-up.

Based on reviews of recipient records, the WMAP believes that recordkeeping can be enhanced by the following good practices:

- including information in the assessment on previous treatment history and outcome, making sure the assessment materials support the diagnosis made, and updating assessment materials as new information becomes available, and
- including information in the discharge summary on the provider's response to non-compliance, including efforts to engage the recipient in treatment, when this was a factor in discontinuing treatment. Also, identify how a return to treatment might be most easily handled.

Refer to Section IV of Part A of the WMAP Provider Handbook for further information regarding recordkeeping.

Outpatient AODA treatment services are a covered benefit when provided under the following conditions:

1. the treatment services are in accordance with the definition of AODA treatment. AODA treatment services are defined in HSS 101.03(13), Wis. Admin. Code, as alcohol and other drug abuse treatment services provided by a certified provider to assist alcoholics and drug abusers and persons affected by problems related to the abuse of alcohol or drugs. Examples of AODA treatment services are client evaluation, orientation and motivation, treatment planning, consultation and referral, client education, individual counseling, group counseling and crisis intervention;

2. before the enrollment in an AODA treatment program, the recipient must receive a complete medical evaluation by a physician. The medical evaluation must be performed within 60 days prior to the first date of AODA services. The evaluation should include diagnosis, summary of present medical findings, medical history, and explicit recommendations and prescription by the physician for participation in the alcohol or drug abuse treatment program;

   This medical evaluation is not a differential diagnostic evaluation. Differential diagnostic evaluations are psychiatric evaluations. A medical evaluation is required to determine the recipient's medical conditions which may have a bearing on the suitability of the person for AODA treatment. The medical evaluation does not count toward the 15 hour/$500 psychotherapy prior authorization threshold or toward the six hour per 2 year limit on psychiatric evaluation.

3. the supervising physician or psychologist develops a treatment plan which relates to behavior and personality changes being sought and to the expected outcome of treatment; and

C. COVERED AODA TREATMENT SERVICES (continued)

4. the provider who performs alcohol and other drug abuse treatment meets the requirements of an AODA treatment provider as described in Section I-B of this handbook and engages in face-to-face contact with the recipient for at least 5/6 of the time for which reimbursement is claimed under the WMAP Program.

Individual AODA Therapy
Individual AODA therapy is a covered service when it meets the criteria listed in the section on "Requirements for AODA Treatment Services." Providers should refer to Appendix 3 of this handbook for information on who may bill for this service and limitations that may apply. Only one provider may bill for the same treatment session.

Family AODA Therapy
Family AODA therapy is covered for the recipient, the immediate member (or members) of the recipient's family, and the recipient's significant others. Immediate family members include parents, foster parents, spouse, children, or foster children. Such a session may involve more than one recipient, but only one provider may bill for one recipient for the same treatment session. No more than two providers may bill for the same family AODA psychotherapy session.

Group AODA Therapy
Group AODA therapy is defined as a session in which more than one but not more than ten individuals (they do not all need to be WMAP recipients) receive AODA therapy services together from one or two providers. No more than two providers may be reimbursed for the same session, and they may not claim reimbursement for the same recipients in the group.

Treatment of Affected Family Members
Treatment of recipients who are affected family members or significant others of individuals with alcohol and other drug abuse problems is covered as an AODA treatment service when the affected recipient has very recently been involved with

an active alcohol or drug abuser and has active treatment issues with the addicted individual regardless of whether the addicted person is still abusing alcohol or drugs, or is in treatment or recovery. The affected family member receiving treatment services must have an allowable ICD-9-cm diagnosis, as listed in Appendix 3 of this handbook. The affected family member may receive individual, group, or family therapy, and the appropriate AODA procedure code should be billed. Refer to Appendix 3 of this handbook for a list of allowable procedure codes.

If the affected individual requires treatment for the effects of his/her relationship with an addicted individual, but no longer are actively involved with that person, the treatment is considered psychotherapy and must meet the requirements listed in Section II-B of this handbook.

AODA Intensive Outpatient Treatment
The WMAP covers AODA intensive outpatient treatment as a 51.42 Board clinic service. Intensive outpatient service consists of a combination of individual, group, and family therapy offered for 4-16 hours per week for 4-16 weeks. Most of this service requires prior authorization. Refer to Section III-B and Appendices 9, 10 and 11 of this handbook for further information on requesting prior authorization for these services.

D. SERVICES PROVIDED TO RECIPIENTS DIAGNOSED AS MENTALLY RETARDED

Psychotherapy or AODA treatment services are not covered for individuals whose primary or only diagnosis is mental retardation (ICD-9-CM diagnosis 317-319). However, the WMAP recognizes that these individuals may have valid mental health or AODA problems distinct from the mental retardation. For purposes of coverage as a WMAP psychotherapy or AODA treatment service, the mental health or AODA diagnosis is considered primary in these situations. In addition to having an allowable ICD-9-CM diagnosis for the procedure billed, the recipient must be able to benefit from the particular treatment provided in order for the service to be reimbursable by the WMAP.

E. HEALTHCHECK "OTHER SERVICES"

The WMAP considers requests for medically necessary mental health/AODA services which are not specifically listed as covered services, or which are listed in this section as noncovered services, when the following conditions are met:

1. the provider verifies that a comprehensive HealthCheck screening has been performed;
2. the service is allowed under the Social Security Act as a "medical service";
3. the service is medically necessary and reasonable to correct or ameliorate a condition or defect which is discovered during a HealthCheck screening;
4. the service is noncovered under the current WMAP state plan; and
5. a service currently covered by the WMAP is not appropriate to treat the identified condition.

All requests for HealthCheck "Other Services" are subject to prior authorization. Refer to Section III-B of this handbook for information on requesting prior authorization.

F. REVIEW OF PSYCHIATRIC AND AODA INPATIENT STAYS

This handbook must be followed by physicians in private practice. Admitting physicians and hospitals are responsible for meeting the requirements in this section.

Prior to elective/urgent admissions and after emergency admissions, the following inpatient hospital stays must be reviewed by the Wisconsin Peer Review Organization (WIPRO):

- all AODA admissions;
- all elective psychiatric admissions; and
- all psychiatric admissions to inpatient hospital programs for individuals under age 21 in an IMD.

This review is used to evaluate the medical necessity of inpatient treatment for WMAP payment purposes. WIPRO makes final determinations of medical necessity of admissions that are "suspect" based on a retrospective review of the recipient's medical record. All psychiatric and AODA hospitalizations are subject to retrospective review by WIPRO based on selection criteria established by the WMAP. Providers should contact WIPRO directly at 1-800-833-7247, if there are questions about this review process. Refer to Appendix 21 of this handbook for additional information on the review process.

G. NONCOVERED SERVICES AND RELATED LIMITATIONS

As specified in HSS 107.13(2)(d), Wis. Admin. Code, the following services are not WMAP-covered outpatient psychotherapy clinic services:

- collateral interviews with persons other than the recipient's immediate family (parents, spouse and children, or for children in foster care, foster parents) and consultations, except as provided in HSS 107.06 (4)(c), Wis. Admin. Code;

G. NONCOVERED SERVICES AND RELATED LIMITATIONS (continued)

- psychotherapy for persons with the primary diagnosis of mental retardation, except when they experience psychological problems that necessitate psychotherapeutic intervention;
- psychotherapy provided in a recipient's home;
- self-referrals ("self-referral" means that a provider refers a recipient to an agency in which the provider has a direct financial interest, or to himself or herself acting as a practitioner in private practice, and
- court appearances except when necessary to defend against commitment.

As specified in HSS 107.13 (3)(d), Wis. Admin. Code, the following services are not WMAP-covered AODA clinic services:

- collateral interviews and consultations with persons other than the recipient's immediate family, except as provided in HSS 107.06 (4)(c), Wis. Admin. Code;
- court appearances except when necessary to defend against commitment; and
- detoxification provided in a social setting, as described in HSS 61.58, Wis. Admin. Code.

As specified in HSS 107.03, Wis. Admin. Code, the following services are not WMAP-covered services:

- psychiatric examinations and evaluations ordered by the court, following the conviction of a crime, pursuant to s. 972.15, Wis. Stats;
- services to a recipient who is an inmate of a public institution or services to a person 21 to 64 years of age who is a resident of an institution for mental diseases (IMD), unless the recipient is 21 years of age, was a resident of the IMD immediately prior to turning 21 and has been continuously a resident since then, unless the recipient is on convalescent leave from an IMD; and
- consultations between or among providers. Direct recipient contact for the purpose of performing an evaluation that forms the basis of a consultation is covered as noted in Section II-C of this handbook.

As specified in HSS 107.13(1)(f), Wis. Admin. Code, the following services are not WMAP-covered outpatient psychotherapy or AODA professional services when provided to hospital inpatients:

- services provided to a hospital inpatient by a master's level psychotherapist or AODA counselor are not separately reimbursable as mental health/AODA professional services when billed by an outpatient psychotherapy clinic; and
- group therapy and medication management are not separately reimbursable as professional mental health or AODA services when provided to a hospital inpatient.

As specified in HSS 107.13(2)(c), Wis. Admin. Code, outpatient psychotherapy services are not reimbursed if the recipient is receiving WMAP-covered community support program (CSP) services.

A. GENERAL REQUIREMENTS

Prior authorization procedures are designed to safeguard against unnecessary utilization of care, to promote the most effective and appropriate use of available services, and to assist in cost containment. Providers are required to seek prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis. Payment is not made for services provided either prior to the grant date or after the expiration date indicated on the approved prior authorization request form. If the provider renders a service which requires prior authorization without first obtaining authorization, the provider is responsible for the cost of the service.

Under normal circumstances, to receive reimbursement from the Wisconsin Medical Assistance Program (WMAP), prior authorization must be obtained before services are performed. However, in the case of provider or recipient retroactive eligibility, or the provision of a service requiring prior authorization which was performed on an emergency basis, retroactive prior authorization may be obtained. Refer to Section III-G of this handbook and Section VIII of Part A of the WMAP Provider handbook for additional information on retroactive prior authorization.

B. SERVICES REQUIRING PRIOR AUTHORIZATION

Psychiatric Evaluations and Diagnostic Testing

Psychiatric evaluations and diagnostic testing are limited to six hours per recipient in a two year period. Evaluation services by any combination of psychotherapy providers count toward this limit. Psychiatric evaluations and diagnostic testing in excess of six hours in a two year period, which are billed as limitation-exceeded psychotherapy, are also subject to the 15 hour or $500 threshold beyond which prior authorization is required. Therefore, providers require prior authorization for these services when they exceed these limits or when a series of testing alone may exceed the six hour limit. Services by a psychiatrist or psychologist provided at the inpatient hospital setting and separately billed as a professional service are not subject to prior authorization.

Providers requesting prior authorization for psychiatric evaluation and testing services must use the Prior Authorization Request Form (PA/RF) and Prior Authorization Evaluation and Testing Attachment (PA/ETA). Refer to Appendices 4 and 5c of this handbook for a sample PA/RF and completion instructions, to Appendices 12 and 13 of this handbook for a sample PA/ETA and completion instructions, and to Appendix 14 of this handbook for a summary of prior authorization guidelines.

Psychotherapy and AODA Treatment Services

Prior authorization is required for most mental health and Alcohol and Other Drug Abuse (AODA) treatment services after a recipient has accumulated 15 hours or $500 (whichever comes first) in allowed services in any calendar year. Appendix 3 of this handbook indicates outpatient psychotherapy services which accumulate toward this limit and which require prior authorization when services exceed 15 hours or $500 of allowed charges to an individual recipient in a calendar year. Outpatient hospital services for mental health or AODA treatment also accumulate towards this threshold. Services by a psychiatrist or psychologist provided at the inpatient hospital setting and separately billed as a professional service are not subject to prior authorization.

The allowed dollar amount is calculated based upon the lesser of the billed amount or the maximum allowable fee for the service as established by the WMAP. Services reimbursed by any health insurance payer count toward this limit. Reimbursement to any outpatient psychotherapy or AODA provider is included when calculating the 15 hours or $500 of allowed service for each individual.

B. SERVICES REQUIRING PRIOR AUTHORIZATION (continued)

Providers requesting prior authorization for psychotherapy services must use the PA/RF and the Prior Authorization/Psychotherapy Attachment (PA/PSYA). Refer to Appendices 4 and 5a of this handbook for a sample PA/RF and completion instructions, to Appendices 6 and 7 of this handbook for a sample PA/PSYA and completion instructions, and to Appendix 8 of this handbook for a summary of prior authorization guidelines.

Providers requesting prior authorization for AODA treatment services must use the PA/RF and the Prior Authorization/AODA Attachment (PA/AA). Refer to Appendices 4 and 5b of this handbook for a sample PA/RF and completion instructions, to Appendices 9 and 10 of this handbook for a sample PA/AA and completion instructions, and to Appendix 11 of this handbook for a summary of prior authorization guidelines.

Emergency Psychotherapy

Although emergency psychotherapy may be provided without first obtaining prior authorization, as described in Section II-B of this handbook, claims for emergency psychotherapy require prior authorization before payment is made if the 15 hour/$500 limit for services in a calendar year has been exceeded. Claims submitted for emergency psychotherapy services which exceed the prior authorization threshold and which do not indicate a valid prior authorization number are denied. Providers should use the standard psychotherapy prior authorization request forms (refer to Appendices 5 and 7 of this handbook) to receive a prior authorization number for emergency services which have been provided. Up to eight hours of emergency psychotherapy in a two-week period may be authorized. The prior authorization request must be received by EDS within two weeks of performance of emergency psychotherapy, must request backdating, and must justify the need for emergency treatment.

Concurrent Mental Health/AODA Prior Authorizations

Prior authorization is normally only granted to one provider at a given time. However, concurrent prior authorizations may be approved for separate providers providing mental health and AODA services. Concurrent prior authorization requests must meet the following requirements:

- The prior authorization requests must clearly indicate that each provider is aware of the services being provided by the other, and that these services are being coordinated.
- Justification must be given for having services provided by separate providers.
- The overall intensity of service must be within the range ordinarily approved for outpatient mental health/AODA (e.g., intensive AODA outpatient treatment is generally not approved concurrently with one to two hours of family psychotherapy per week, but one 2-hour AODA group therapy session plus one 1-hour individual psychotherapy session may be approved).

Concurrent Outpatient Mental Health and Medical Day Treatment Services

Outpatient psychotherapy or AODA therapy may be provided concurrently with medical day treatment services which are considered medically necessary and appropriate when the following conditions are met:

1. the recipient's diagnosis is appropriate for both services (refer to the guidelines used to process prior authorization requests);
2. there is documentation that the providers are communicating with each other about the recipient's needs, the treatment is coordinated, and the outpatient and day treatment services augment one another; and

B. SERVICES REQUIRING PRIOR AUTHORIZATION (continued)

3. when one of the following statements is true:

   a. there is a pre-existing relationship between the recipient and the outpatient provider;

   b. the recipient has appropriate day treatment needs, but the recipient also has a need for specialized intervention which the day treatment staff is not trained to provide; or

   c. the recipient is transitioning from day treatment to outpatient services.

The day treatment provider is required to request prior authorization for any day treatment services requested for a recipient who is also receiving outpatient services.

In general, a recipient who is able to benefit from outpatient services does not require as high a level of day treatment services and the consultant may modify the hours requested based on clinical judgement.

HealthCheck "Other Services"

All requests for services under the HealthCheck "Other Services" benefit require prior authorization. Providers should submit a PA/RF indicating the description of the service (but leaving blank the section requesting the procedure code, as one is assigned by EDS) and the number of hours of service requested. To expedite processing of the request, write "HealthCheck Other Services" or "HOS" in red ink at the top of the PA/RF. The provider must submit documentation that the recipient received a comprehensive HealthCheck screening in the past year. A physician's prescription for the particular treatment service is required. Additional information documenting the recipient's need for the service and the appropriateness of the service being delivered must be supplied by the provider.

C. WHEN TO REQUEST PRIOR AUTHORIZATION

Because a provider may have no way of knowing whether or not a recipient has received services from another provider and has, therefore, reached the prior authorization threshold, providers are encouraged to request prior authorization as soon as possible when providing psychotherapy or AODA services. Because the WMAP ordinarily grants prior authorization to only one psychotherapy/AODA provider at a time, making the prior authorization request helps protect the provider against potential denial of services.

Any part of the 15 hours or $500 of services which may be reimbursed without prior authorization that is not used, remains available for use by the recipient for the remainder of the calendar year.

Providers are advised that prior authorization does not guarantee payment. Provider eligibility and recipient eligibility on the date of service, as well as all other WMAP requirements must be met prior to payment of the claim.

Non-billing performing providers (master's degree psychotherapists or AODA counselors) requesting prior authorization must indicate the group or clinic provider name and number as the billing provider on the Prior Authorization Request Form (PA/RF).

D. PRIOR AUTHORIZATION CRITERIA

Appendices 8, 11, and 14 of this handbook summarize the criteria which are used to process prior authorization requests for psychotherapy, AODA, and psychiatric evaluations and testing. A copy of the complete guidelines used to process prior authorization requests may be obtained by writing to:

D. PRIOR AUTHORIZATION CRITERIA (continued)

Mental Health/AODA Policy Analyst
Bureau of Health Care Financing, Room 250
Division of Health
Post Office Box 309
Madison, WI 53701

Prior authorization requests may be returned to providers for additional information when the initial request does not contain adequate information to process the prior authorization request. Returned requests are not denials. Providers are responsible for providing adequate, updated, information to allow the mental health/AODA consultants to determine the appropriateness of the service being requested. The additional information must be added to the returned request and resubmitted to EDS. Do not complete a new PA/RF.

E. PROCEDURES FOR OBTAINING PRIOR AUTHORIZATION

Section VIII of Part A of the WMAP Provider Handbook identifies procedures for obtaining prior authorization including emergency situations, appeal procedures, supporting materials, retroactive authorization, recipient loss of eligibility midway in treatment, and prior authorization for out-of-state providers.

The appropriate prior authorization request forms and attachments along with their completion and submittal instructions are given in Appendices 4, 5, 6, 7, 9, 10, 12 and 13 of this handbook.

Completed prior authorization request forms must be submitted to:

EDS
Attn: Prior Authorization Unit - Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Prior authorization request forms may be obtained by submitting a written request to:

EDS
Attn: Claim Reorder Department
6406 Bridge Road
Madison, WI 53784-0003

Please specify the prior authorization form requested and the number of forms desired. Reorder forms are included in the mailing of each request for forms. Do not request forms by telephone.

F. SERVICE INTERRUPTIONS

If a provider is unable to utilize all prior authorized services during the prior authorization grant period due to unforeseeable interruptions in service (e.g., recipient illness or vacation), the provider may request an extension of the grant period. The provider should write a letter indicating the change requested and the reason and attach it to a copy of the PA/RF and send these to the EDS Prior Authorization Unit. Gaps in service exceeding one month require special justification.

If a recipient transfers to another mental health or AODA provider before the expiration of a prior authorization period, the provider should notify the EDS Prior Authorization Unit of the exact date care is terminated so that a new prior authorization may be granted.

G. GRANT DATES AND BACKDATING FOR PRIOR AUTHORIZATIONS

Determination of Grant Dates

The prior authorization grant date (i.e., the first date of service which may be reimbursed under the authorization), is the date the prior authorization request is reviewed by the WMAP mental health consultant, or the date the request is first received by EDS if this date is deemed appropriate for continuity of care reasons by the WMAP mental health consultant. See Section VIII of Part A of the WMAP Provider Handbook.

Procedures for Backdating Prior Authorization Requests

Backdating of prior authorization requests up to two weeks prior to the date the prior authorization request is received at EDS may be allowed at the discretion of the WMAP mental health consultant. The provider must request backdating and must indicate the clinical rationale for the request on the prior authorization attachment or in a narrative submitted with the prior authorization request.

Backdating for Services by Multiple Providers Exceeding the Prior Authorization Threshold

Providers may request backdating of prior authorizations to cover services which are denied because they exceeded the prior authorization threshold. In these cases, authorization may be granted for services provided more than two weeks prior to the receipt of the prior authorization request at EDS. Requests for backdating prior authorization are considered if the following conditions are met:

- More than one provider must have provided service during the period for which backdating is requested;
- The provider must document an inability to obtain information from the recipient or other provider which would have allowed the provider to determine that prior authorization would have been required.

A. COORDINATION OF BENEFITS

The Wisconsin Medical Assistance Program (WMAP) is the payer of last resort for any WMAP-covered service. If the recipient is covered under health insurance (including Medicare), the WMAP reimburses that portion of the allowable cost remaining after all other health insurance sources have been exhausted. Refer to Section IX of Part A of the WMAP Provider Handbook for more detailed information on services requiring health insurance billing, exceptions, and the "Other Coverage Discrepancy Report."

Psychotherapy and AODA services provided to a recipient which have been paid for by another health insurance payer count toward the yearly 15 hour/$500 threshold beyond which prior authorization is required.

B. MEDICARE/ MEDICAL ASSISTANCE DUAL ENTITLEMENT

Recipients covered under both Medicare and Medical Assistance are referred to as dual-entitlees. Claims for Medicare-covered services provided to dual-entitlees must be billed to Medicare prior to billing Medical Assistance.

If the recipient has Medicare, but Medicare benefits are not available (e.g., Medicare benefits exhausted), a Medicare disclaimer code must be indicated on the claim, as indicated in the claim form instructions in Appendix 1 of this handbook.

C. MEDICARE QMB-ONLY

Qualified Medicare Beneficiary only (QMB-only) recipients are only eligible for WMAP payment of the coinsurance and the deductibles for Medicare-covered services. Since Medicare does cover some psychotherapy/AODA services, claims submitted for QMB-only recipients for Medicare-allowed services may be reimbursed.

D. BILLED AMOUNTS

Providers must bill the WMAP their usual and customary charge for services provided, that charge being the amount charged by the provider for the same service when provided to private-pay patients. For providers using a sliding fee scale for specific services, usual and customary means the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Providers may not discriminate against Medical Assistance recipients by charging a higher fee for the service than is charged to a private-pay patient.

The billed amount should not be reduced by the amount of recipient copayment. The applicable copayment amount is automatically deducted from the payment allowed by the WMAP.

Providers should refer to Appendix 1 of this handbook for complete billing instructions.

E. CLAIM SUBMISSION

Paperless Claim Submission

As an alternative to submission of paper claims, EDS is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as claims submitted on paper and are subjected to the same processing requirements as paper claims. Providers submitting electronically may usually reduce their claim submission errors. For additional information on paperless claim submission, complete the form found in Appendix 20 of this handbook or contact the Electronic Media Claims (EMC) Department at:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

E. CLAIM SUBMISSION (continued)

Paper Claim Submission

Claims for psychotherapy and AODA services must be submitted using the National HCFA 1500 claim form. Sample claim forms and completion instructions may be found in Appendices 1 and 2 of this handbook.

Claims for psychotherapy and AODA services submitted on any other paper form than the HCFA 1500 claim form are denied.

The HCFA 1500 claim form is not provided by the WMAP or EDS. It may be obtained from a number of forms suppliers.

One such source is:

State Medical Society Services
Post Office Box 1109
Madison, WI 53701
(608) 257-6781 (Madison Area)
1-800-362-9080 (Toll-Free)

Completed claims submitted for payment must be mailed to the following address:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Submission of Claims

All claims for services rendered to eligible WMAP recipients must be received by EDS within 365 days from the date the service was rendered. Claims for coinsurance and deductible for services rendered to recipients covered by both Medicare and Medical Assistance must be received by EDS within 365 days from the date of service, *or* within 90 days from the Medicare EOMB date, whichever is later. (Refer to Section IX of Part A of the WMAP Provider Handbook for exceptions to the 90-day extension.) This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals may be found in Section IX of Part A of the WMAP Provider Handbook.

F. TYPES OF PROVIDERS

Billing Providers

Psychotherapy clinics, psychiatrists, psychologists, AODA clinics and physicians are issued billing performing provider numbers which may be used to independently bill the WMAP. All claims must indicate the billing performing provider name and number on the HCFA 1500 claim form. Services performed by the billing performing provider may be billed by:

- Indicating the billing performing provider name and number in element 33 of the HCFA 1500 claim form (in which case all payment is made directly to the billing performing provider.)

NOTE: Staff providing services in a 51.42 Board Owned-and-Operated psychotherapy or AODA clinic which are billed to the WMAP must meet the certification criteria in Section I-B of this handbook but do not need to be individually certified by the WMAP.

F. TYPES OF PROVIDERS (continued)

Non-Billing Providers (Master's Degree Psychotherapists or AODA Counselors)
Master's degree psychotherapists and AODA counselors are issued non-billing performing provider numbers which may not be used to independently bill the WMAP. All claims must be billed under the group or clinic provider name and number. Services performed by the non-billing performing provider may be billed by:

- Indicating the group or clinic provider name and number in element 33 of the HCFA 1500 claim form (in which case all payment is made directly to the group or clinic provider number.)

NOTE: Staff providing services in a 51.42 Board Owned-and Operated psychotherapy or AODA clinic which are billed to the WMAP must meet the certification criteria in Section I-B of this handbook but do not need to be individually certified by the WMAP.

G. DIAGNOSIS CODES

All diagnoses listed on the HCFA 1500 claim form must be from the International Classification of Diseases, 9th Edition, Clinical Modifications (ICD-9-CM) coding structure. An allowable diagnosis code must be indicated for each procedure performed. Refer to Appendix 3 of this handbook for allowable diagnoses for specific procedure codes.

Claims received without the appropriate ICD-9-CM code are denied.

The complete ICD-9-CM code book may be ordered by writing to the address listed in Appendix 3 of Part A of the WMAP Provider Handbook.

Providers should note the following diagnosis code restrictions:

- Codes with an "E" prefix must not be used as the primary or sole diagnosis on a claim submitted to the WMAP.
- Codes with an "M" prefix are not acceptable on a claim submitted to the WMAP.

Providers should note that the Prior Authorization Request Form (PA/RF) also requires ICD-9 diagnosis codes, but the prior authorization attachment forms request the most recent version of DSM diagnosis code.

H. PROCEDURE CODES

HCFA Common Procedure Coding System (HCPCS) codes are required on all psychotherapy and AODA claims. Claims or adjustments received without HCPCS codes are denied. Allowable HCPCS codes for psychotherapy and AODA services are included in Appendix 3 of this handbook.

I. PSYCHOTHERAPY MEDICATION MANAGEMENT (MEDICATION CHECK)

Up to 30 minutes of psychotherapy medication management may be billed per date of service and up to one hour per calendar month.

J. FOLLOW-UP TO CLAIM SUBMISSION

It is the responsibility of the provider to initiate follow-up procedures on claims submitted to EDS. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Providers are advised that EDS takes no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to EDS. Section X of Part A of the WMAP Provider Handbook includes detailed information regarding:

- the Remittance and Status Report;

J. FOLLOW-UP TO CLAIM SUBMISSION (continued)

- adjustments to paid claims;
- return of overpayments;
- duplicate payments;
- denied claims; and
- Good Faith claims filing procedures.